Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

## I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 8-10-01 and 8-22-01.
   b. The request was received on 7-22-02.

## II. EXHIBITS

1. Requestor, Exhibit 1:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA's
   c. EOBs
   d. Medical Documentation
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFA's
   c. EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 8-8-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 8-9-02. The response from the insurance carrier was received in the Division on 8-23-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

## III. PARTIES' POSITIONS

1. Requestor: Letter dated 8-1-02:
   "We are requesting our service dated 08/10/01 through 08/22/01 in the amount of $380.00 to be paid as we billed…. (Claimant) came into our office on 09/07/01 for a physical performance evaluation. This is not a Functional Capacity Evaluation (FCE), an FCE is a more detailed and more in depth test. This particular procedure is for the Physical Performance test (PPE) which entails a series of test of strength, flexibility,

endurance, pain, cardiovascular fitness, material handling ability, coordination, static posturing, repetitive movements, and any other tests which will help to determine the patients [sic] safe maximum ability to work. It is a measurement (eg, musculoskeletal functional capacity), with a written report for each 15 minuets [sic]. The Physical Performance tests are done in tow [sic] hour increments and therefore the time duration would be 120 minutes per PPE. Also on 08/22/01 the patient had a range of motion test performed which consist [sic] of the patients [sic] degree of flexibility in the spine and extremities."

2. Respondent: Letter dated 8-23-02:

"In dispute are billings under CPT Code 97750 for date of service 8-10-01 and 3-14-02. Also in dispute in billing under CPT Code 95851 for date of service 8-22-01. Provider has failed to document the medical necessity of the functional capacity evaluations billed under 97750 or the range of motion testing under 95851. Carrier contends that these services were neither appropriate or necessary for the treatment or evaluation of the patient and were not justified under the medical treatment guidelines."

## IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 8-10-01 and 8-22-01.

2. The Carrier has denied the disputed services as reflected on the EOBs as, "D – DENIAL AFTER RECONSIDERATION; N – NOT APPROPRIATELY DOCUMENTED; NO ADDITIONAL RECOMMENDED ALLOWANCE REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED."

3. The provider billed $380.00 for dates of service 8-10-01 and 8-22-01. The Carrier paid $-0- for both dates of service. The amount in dispute is $380.00.

## V. RATIONALE

Medical Review Division's rationale:

The carrier has supplied reconsideration EOBs that reflect a denial of "N – NOT APPROPRIATELY DOCUMENTED; NO ADDITIONAL RECOMMENDED ALLOWANCE REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED."

General Instructions (II) indicates, "Ground rules, presented at the beginning of each section, provide definitions necessary to correctly interpret, report, and reimburse the services and procedures, contained in that section. Ground rules also provide explanations of terms that apply only to that particular section." The Commission cannot alter the CPT codes but can develop ground rules that are more expansive in order to explain how the code is to be interpreted by the parties. It is clear from the General Instructions that the Ground Rules are not restricted by the code, but were written in order to adapt the codes for the Commission's needs.

Therefore, the MGR should be interpreted as an expansion of the code descriptor. MGR (I) (C) (1), indicates 97750 is to be used with modifier, -FC or –MT. No modifier was noted on the HCFA 1500. The appropriate section of the MGR, (I) (E), would then apply. (I) (E) (2) indicates, "FCEs are allowed a maximum of three times for each injured worker." It also indicates the payments to be made for the 3 tests and what elements a FCE should contain however, the code as billed does not reflect that a FCE was performed.

MGR (I) (E) (3) describes muscle testing (97750-MT). The ground rule indicates that 97750-MT , " …shall be reimbursed per body area (see section (I) (D) (1) of the ground rules for this section). If two or more contiguous areas are injured and if testing requires no additional tasks, then reimbursement shall be allowed for only one body area. Muscle testing shall not be reimbursed in addition to a functional capacity evaluation (FCE). Muscle testing may be used to replace any six components of the functional abilities test and shall be reimbursed (by time required) as a component of the FCE, not exceeding the MAR for an FCE." MGR (I) (D) describes the body areas. Per the medical reports supplied by the carrier, the claimant had injured her low back. The 08-10-01 report indicates, "(Claimant) performed a standardized isometric strength protocol…." Per the MGR (I ) (E) (3) (a), isometric measurements are part of muscle testing. Therefore, the provider incorrectly coded the muscle test by failing to use the correct modifier. The MAR for muscle testing to one body area is $43.00.

Therefore, reimbursement for the muscle test completed is recommended in the amount of **$43.00.**

The provider has also billed for CPT Code 95851 Range of Motion Testing. The carrier has denied the disputed code as "N – NOT APPROPRIATELY DOCUMENTED; NO ADDITIONAL RECOMMENDED ALLOWANCE REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED." Documentation does support that the services were rendered. The report substantiates that flexion and extension range of motion testing was performed to the claimant's lumbar area.

Therefore, reimbursement is recommended in the amount of **$36.00**.

Total recommended reimbursement is **$79.00.**

## V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$79.00** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 24th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

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